For _____ School Year
(expires at the end of August)

Must be accompanied by "Permission to Administer Medication at School" (PTAM) Form

SHORELINE SCHOOL DISTRICT
TREATMENT ORDER FORM: LIFE THREATENING ALLERGY
LICENSED HEALTH CARE PROVIDER* (LHP) ORDERS

Note: These orders *must* be renewed every year, before the beginning of each school year.

Cascade K-8 Community School 2800 NE 200th St Shoreline, WA 98155	ATTENTION: Julie Etscheid, BSN, RN Phone: 206-393-4187 Fax: 206-393-4183

Student Name:_____ Birth date _____ Grade/Grad Yr_____

LHP* Name _____Phone_____ Fax _____

MEDICAL INFORMATION AND ORDERS – TO BE COMPLETED BY LHP*
Please complete these treatment orders so we can better understand the student's needs*

STUDENT HEALTH HISTORY:

Student has a severe allergy to: _____

Student has a history of anaphylaxis ☐ **Yes** ☐ **No** Last anaphylactic reaction (Date) _____

Student has a history of asthma ☐ **Yes** (High Risk for Severe Reaction) ☐ **No**

Weight: _____

Other related health history:_____

TREATMENT PLAN: IF ANAPHYLAXIS IS SUSPECTED:+

1. Give epinephrine auto-injector and call 911.
2. Repeat dose of epinephrine if available in _____ minutes if no improvement, if available.
3. Give antihistamine and inhaler (bronchodilator) if available (*see attached PTAM form for med orders*).
4. Other:

_____

Student may carry emergency medication in backpack: ☐ YES ☐ NO

Student may self-administer epinephrine auto-injector: ☐ YES ☐ NO

Student has demonstrated use of epinephrine auto-injector to LHP* ☐ YES ☐ NO

Additional instructions for certain students:

The student is **EXTREMELY** reactive to the following allergen(s):

_____

☐ If checked, give epinephrine immediately if student LIKELY exposed to allergen, for ANY symptoms.

☐ If checked, give epinephrine immediately if student DEFINITELY exposed to allergen, even if no symptoms are apparent.

_____ _____ _____

Licensed Health Care Provider* Signature **Date** **Phone**

*MD, DO, ARNP, PA, ND

+Any of the following symptoms:

LUNG: Shortness of breath, wheezing, repetitive cough
HEART: Pale or bluish skin, faintness, weak pulse, dizziness
THROAT: Tight or hoarse throat, trouble breathing or swallowing
MOUTH: Significant swelling of the tongue or lips
SKIN: Many hives over body, widespread redness
GUT: Repetitive vomiting, severe diarrhea
OTHER: Feeling something bad is going to happen, anxiety, confusion
STUDENT SPECIFIC:_____

+OR A COMBINATION OF MILD SYMPTOMS FROM DIFFERENT BODY AREAS.

*MD, DO, ARNP, PA, ND